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Regulating Work That Kills Us Slowly: The Challenge of Chronic Work-Related Health Problems

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Abstract

New Zealand has a long history of neglecting the chronic health effects of work. Recent health and safety reforms, including the new Health and Safety at Work Act 2015, risk continuing this neglect, with serious negative consequences for worker health. This paper proposes three areas of legislative reform needed to begin to tackle the growing challenge of chronic work-related health problems in New Zealand.

Key words

Health and safety, psychosocial hazards, compensation.

Introduction

The Health and Safety at Work Act 2015 (HSWA) was a response to New Zealand's poor record of occupational health and safety, highlighted in the *Report of the Royal Commission on the Pike River Mine Tragedy*[1] and the *Report of the Independent Taskforce on Workplace Health and Safety*.[2] The HSWA forms part of the Working Safer Reform Package,[3] which includes greater powers for the regulator, tougher penalties, and the establishment of a national target to reduce serious injuries and fatalities.[4] While these measures are good, they do little to address New Zealand's systemic failure in responding to chronic work-related harm. The Independent Taskforce described New Zealand's response as a "tragic paradox":[5]

> While New Zealand's acute harm and workplace safety statistics are woeful and rightly attract considerable attention, the much more damaging occupational health impacts of the workplace go almost completely under the radar.

The chronic work-related health problems going under the radar in New Zealand include depression, anxiety, drug and alcohol abuse, pain syndromes, neurological and reproductive disorders, sleep disorders, respiratory disease, suicide, heart disease and many cancers. These chronic health effects of work are a significant problem, estimated by WorkSafe to result in an

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[1] Royal Commission on the Pike River Coal Mine Tragedy *Report of the Royal Commission on the Pike River Coal Mine Tragedy* (October 2012).

[2] Independent Taskforce on Workplace Health and Safety *The Report of the Independent Taskforce on Workplace Health and Safety: He Korowai Whakaruruhau* (April 2013).

[3] Ministry of Business, Innovation and Employment (MBIE) *Working Safer: Blueprint for New Zealand's Health and Safety System* (August 2013).

[4] Ministry of Business, Innovation and Employment (MBIE) *Working Safer: Reducing Work-Related Fatalities and Serious Injury by 2020: Progress Toward the Target* (March 2015).

[5] Independent Taskforce on Workplace Health and Safety, above n 2, at 16.

additional 600-900 deaths,[6] and affecting tens of thousands more workers,[7] each year. Chronic work-related health problems pose an urgent challenge for New Zealand's health and safety and accident compensation laws, which were designed for the "accidents" that occurred in 20th century factories, mines and workshops and not for the health consequences of poor job design, bullying or stress.

New Zealand has a long history of ignoring the chronic health effects of work. In 2008, the National Occupational Health and Safety Advisory Committee (NOHSAC) technical report concluded that New Zealand's response is less favourable than in comparable countries, and results in injustice, reduced rehabilitation and return to work prospects, inappropriate and delayed interventions, increased costs to public health, and a lack of reporting and prevention activity.[8] In the current *Occupational Health Action Plan*, WorkSafe acknowledges that "workplace exposure to identified health hazards often ends up as a 'poor cousin' to injury prevention and management of safety hazards."[9] Despite recognising the problems, successive governments have decided not to address the issues due to "cost implications" and "policy difficulties."[10] This pattern has sadly continued in the *Working Safer* reforms, with occupational diseases excluded from the current *Working Safer* national targets because this area is "too difficult to monitor."[11] While the policy documents are full of high-sounding statements on the importance of occupational health, there is little concrete change being proposed. In a climate of waning political enthusiasm for health and safety there is a real risk that chronic work-related health problems will be placed back in the "too hard basket."[12]

This paper proposes three areas of legislative reform needed to address New Zealand's chronic work-related harm problems. First, the chronic health effects of work need to be given equal treatment to accidental workplace injury in the Accident Compensation Corporation (ACC) cover provisions, including chronic work-related mental health problems. Second, New Zealand needs to set regulatory standards for a healthy job, not just a safe one, including prevention and monitoring requirements beyond "plant, substances, and structures".[13] Third, the HSWA needs a different set of inspection and enforcement tools, including a new statutory 'right to request' in relation to health and safety.

Reforms to ACC Coverage Provisions and Data Collection

The ACC scheme is a significant, but sometimes overlooked, part of New Zealand's occupational health and safety regime. Its "primary function" under statute is to "reduce the incidence and severity of personal injury" and to provide "a framework for the collection, coordination, and analysis of injury related information."[14] Any meaningful attempt to address

[6] Latest estimate on the WorkSafe website as at 24 August 2015 <www.worksafe.govt.nz>.
[7] Although there are no reliable figures on this, the National Occupational Health and Safety Advisory Committee (NOHSAC) 2004 figures were estimated at over 20,000.
[8] Allen and Clarke *National Occupational Health and Safety Advisory Committee Technical Report to Government No 11 Defining Work-Related Harm: Implications for Diagnosis, Rehabilitation, Compensation and Prevention* (NOHSAC, 2009).
[9] Department of Labour *Occupational Health Action Plan to 2013: Workplace Health and Safety Strategy for New Zealand to 2015* (Originally issued December 2011 but revised) at 5.
[10] *NOSHAC Technical Report*, above n 8.
[11] MBIE *Working Safer: Reducing Work-Related Fatalities*, above n 4, at 20.
[12] Independent Taskforce on Workplace Health and Safety, above n 2, at 32.
[13] HSWA, s 36(3)(d).
[14] Accident Compensation Act 2001, s 3.

the "tragic paradox" of chronic work-related harm requires reform to the coverage provisions of the ACC legislation. At present, a large number of work-related health conditions are excluded from the cover of the ACC scheme. This leaves large numbers of workers without support and assistance and creates unfair distinctions between workers in different industries. Further, in New Zealand work-related harm statistics come almost exclusively from ACC administrative data, which means where there is no ACC cover, there is no resulting data. The lack of information on excluded occupational health conditions is a recognised problem by WorkSafe[15] and is part of the reason for the prior lack of policy response, and the exclusion of chronic harm from the *Working Safer* targets. The current package of reforms anticipate ACC and WorkSafe "working together" more to "coordinate" the data they collect,[16] but do not address the fundamental issues of patchy and inconsistent occupational health coverage.

A Lack of ACC Cover for Chronic Work-Related Health Problems

The ACC scheme covers "accidents" as defined in s 25 of the Accident Compensation Act 2001 (ACA) and some work-related harms resulting from "gradual processes, diseases or infection," so long as they meet the test in s 30, or are included in the Occupational Diseases Schedule. The schedule provides a list of classic occupational diseases such as lead or arsenic poisoning, silicosis, a limited range of zoonosis diseases (from animals and carcasses) and a limited range of diseases from inhaling toxic substances containing dusts or fumes. Section 30 provides a test for any other gradual processes, diseases or infections (except mental harm). It is essentially formulated to cover an "occupational disease", being a disease contracted by the employee who is employed in the type of work where the particular disease has been accepted as more likely to occur, rather than simply a disease that can be factually shown to have been caused by the particular person's work. The difference may seem nuanced but matters a great deal at the margins of cover, as discussed further below.

A particularly significant exclusion from cover are chronic mental health problems arising from work. Mental injury is defined in the ACA as "a clinically significant behavioural, cognitive, or psychological dysfunction."[17] Cover is limited to mental injuries that arise "because of a physical injury"[18] and those caused by certain criminal acts.[19] Section 21B, inserted in 2008, extended cover to work-related mental harm resulting from very narrowly defined single incident trauma (for example, a train driver whose train hits a suicidal person and develops post-traumatic stress disorder (PTSD)). There is no cover for chronic work-related mental conditions, such as a police officer who develops PTSD due to multiple traumatic exposures,[20] pain syndromes as a result of repetitive work,[21] stress-related mental illnesses such as depression or anxiety,[22] or any stress-related physical illness, which at its most expansive includes heart attacks, strokes and alcohol and other drug addictions resulting from stressful work.[23]

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[15] MBIE *Working Safer: Blueprint*, above n 3, at 10.
[16] At 32.
[17] Section 27.
[18] Section 26(1)(c).
[19] Schedule 3 lists the covered sexual offences.
[20] *ETN v ACC* [1998] NZACC 227; *Gable v ACC* [2003] NZACC 212.
[21] *Meikle v ACC* [2008] NZACC 158; *Teen v ACC and Telecom Ltd* [2002] NZACC 244.
[22] *Nilson-Reid v Attorney-General in respect of the Director-General of the Department of Conservation* [2005] 1 ERNZ 951 (EC); *Rosenberg v Air New Zealand Ltd* ERA Auckland AA311/09, 1 September 2009; *Davis v Portage Licensing Trust* [2006] 1 ERNZ 286.
[23] *Attorney-General v Gilbert* [2002] 2 NZLR 342.

Consequences of Exclusion from ACC Cover

If an employee suffers from an excluded condition caused by their employment they must sue their employer to obtain compensation. The claim for compensation usually takes the form of a personal grievance for unjustifiable disadvantage, (the disadvantage being the employer's failure to meet their health and safety obligations to the employee), breach of an implied term of the employment contract, or, less often, a tort claim for breach of statutory duty or negligence. These actions require the employee to prove the employer's fault, which the New Zealand Court of Appeal has described as posing "formidable obstacles."[24] For many chronic health conditions, especially those with long lead-in times, it is nearly impossible to prove the required relationship of causation between employment and resulting illness. Time limitations on bringing claims (90 days for grievances) also limit the potential of such claims for many illnesses.

If successful, an employee's personal grievance remedies are usually limited to the remedies of reimbursement of lost wages (generally capped at 12 weeks' ordinary time) and compensation for "humiliation, loss of dignity, and injury to the feelings."[25] Personal grievance compensation, however, is intended to be an award for the intangible harms of the employer's unjustifiable conduct, not to provide for treatment, ongoing income support for incapacity, or rehabilitation. The sums awarded in these employment cases (including the contractual and tortious claims) are rarely generous and are often not equivalent to the compensation available under ACC for a physical accident. If a worker is not an employee, then their options are limited to claims of negligence, breach of contract (if the contract provides for health and safety), or breach of statutory duty (assuming they are owed a duty).

In the absence of a successful compensation claim, a worker suffering from an excluded work-related health condition has only the benefit system to fall back on. In 2013, research was conducted into the socioeconomic impact of the difference in financial support between ACC and Work and Income New Zealand on a group of people of a similar age and level of functional impairment.[26] The study concluded that those in the illness group (not covered by ACC) had "considerably poorer socio-economic outcomes," did not return to work as early, and were the "most vulnerable for decline into poverty and ill health."[27]

Codifying an Outdated Mind/Body Dualism

The blanket exclusion of chronic work-related mental health problems has a particularly detrimental effect on attempts to improve occupational mental health, codifying an outdated division between mind and body and potentially affirming the belief that mental health problems are less 'real' or 'deserving' than physical health problems. Advances in medical science have resulted in the abandonment of a strict separation between mental and physical illnesses.[28] The *Diagnostic and Statistical Manual of Mental Disorders,* the bible of diagnostic criteria for psychologists, concludes that the "term mental disorder unfortunately implies a distinction between 'mental' and 'physical' disorders that is a reductionist anachronism of

[24] *Attorney-General v Gilbert*, above n 23, at [87].
[25] Employment Relations Act 2000, s 123(1)(c)(i).
[26] Susan McAllister and others "'Do different types of financial support after illness or injury affect socio-economic outcomes? A natural experiment in New Zealand" (2013) 85 Soc Sci Med 93.
[27] McAllister and others, above n 26.
[28] See discussion on the use of the term 'mental' in medicine in Robert Kendell "The Distinction Between Mental and Physical Illness" (2001) 178 BJP 490 at 493.

mind/body dualism," retained in the title only "because we have not found an appropriate substitute."[29] A review of the growing literature on illnesses such as depression reveals complex disease processes that defy a strict mind or body categorisation.[30]

Maintaining a legislative line between mind and body has also resulted in the judiciary being handed the unenviable task of declaring which medical conditions are 'mental' or 'physical' in the absence of medical consensus.[31] The factual difficulty in distinguishing between mind and body is highlighted in the ACC cases of workers suffering with chronic pain conditions, as in *Teen v ACC and Telecom Ltd* and *Meikle v ACC.* For example, consider the position of two employees performing a data-entry job involving long hours of typing. Employee A develops carpal tunnel syndrome in the right wrist and employee B develops a complex regional pain syndrome in the right wrist. Both employees experience physical pain associated with the nerves in that wrist. Employee A's condition is caused by pressure on the nerves. Employee B's condition is thought to be caused by a psychological interaction with the nervous system that causes the involuntary misfiring of pain signals to the nerves, rather than specific tissue damage (although it may be triggered by specific tissue damage). Although there is a recognised psychological component to employee A's condition, it is considered physical, and although there is a recognised physical component to employee B's condition, it is considered psychological by ACC, and thus excluded from cover.[32] Leaving aside any question of whether it is fair to treat employees A and B differently, the distinction between their conditions is, as a matter of fact, very difficult to draw.

The exclusion of mental health problems from ACC cover also has an impact on employers operating businesses in industries where the work performed has a greater mental hazard profile than physical. The lack of ACC cover has a direct consequence for the cost and management of sick leave, employee absence, rehabilitation and return-to-work planning. Employers are also exposed to civil liability for an employee's work-related mental harm in a way they are not with physical harm. The absence of standards and enforcement activity in this area[33] has resulted in little guidance for employers on what amounts to "all reasonably practicable steps" in relation to employee mental health, meaning that it is both more difficult to prevent and defend against employee claims if they are brought.

The Need to Address Work-Related Mental Health Problems

The lack of statistical information on excluded health conditions makes it hard to say how big the problem of work-related mental health in New Zealand is. Helpfully, there is data from Australia, where work-related mental harm is compensable and from which some extrapolation is possible.[34] The Australian research concludes that "mental illness is now the leading cause

[29] American Psychological Association *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, Washington DC, 1994) at Introduction 1.

[30] See Brian Shenal, David Harrison and Heath Demaree "The Neuropsychology of Depression: A Literature Review and Preliminary Model" (2003) 13(1) Neuropsychol Rev 33, and Dominique Musselman, Dwight Evans and Charles Nemeroff "The Relationship of Depression to Cardiovascular Disease: Epidemiology, Biology and Treatment" (1998) 55(7) Arch Gen Psychiat 580.

[31] See *ETN v ACC* and *Gable v ACC*, above n 20; *Teen v ACC and Telecom Ltd* and *Meikle v ACC*, above n 21.

[32] Based on case law. For discussion of these disorders see Richard Mayou and others "Somatoform Disorders: Time for a New Approach in DSM-V" (2005) 162 Am J Psychiat 847.

[33] The only prosecution in the area has been *Department of Labour v Nalder & Biddle (Nelson) Ltd* DC Nelson CRN 04042500, 13 April 2005.

[34] Safe Work Australia, *The Incidence of Accepted Workers' Compensation Claims for Mental Stress in Australia* (April 2013).

of sickness absence and long-term work incapacity in most developed countries,"[35] costing Australian businesses between $11-12 billion each year in absenteeism, reduced work performance, increased turnover rates and compensation claims.[36] The 2013 Safe Work Australia report, *The Incidence of Accepted Workers' Compensation Claims for Mental Stress,* stated that such claims amounted to about 10 per cent of the total claims made, but were the most expensive, requiring longer periods of absence from work.[37] The highest number of claims was for "work pressure related illness." Harassment and bullying had the second highest number of claims, and then "exposure to workplace violence."[38] Claims increased with worker age, with men aged 55-59 and women aged 50-54 making the most claims.[39] Younger workers were more likely to be exposed to occupational violence and women were more likely to be sexually harassed. Women accounted for 58.6 per cent of mental stress claims (women making up only 33.6 per cent of total workplace injury claims).[40] Those most at risk were drivers for public transport, law and order occupations, those in caring and health professions and teachers.[41]

The rise in work-related mental health problems in Australia has been attributed to changes in the labour market and the nature of work, with more employees involved in "mental" work.[42] These changes can also be seen in New Zealand. According to the latest *New Zealand Sectors Report 2014*, "services" make up 52 per cent of the total work force, with government, education and health a further 28.1 per cent. This dwarfs the numbers of people employed in mining, primary industries, manufacturing and the booming construction sectors (35.5 per cent combined),[43] which are the focus of occupational health and safety and injury prevention activity. Service industries, education and health also generated 90 per cent of job growth in 2002–2012,[44] suggesting a growing number of people potentially affected. The number of employees in New Zealand performing what could be described as primarily mental work, and thus exposed to the hazards of that work, is considerable. While not all service, health and education sector workers will develop health problems, it is important to ask why these workers are not entitled to ACC cover for the harms that logically result from the type of work they do.

The lack of ACC cover for these workers jars with the approach of the occupational health and safety legislation. The Health and Safety in Employment Act 1992 (HSEA) and the new HSWA provide for no difference in the employer's general legal obligations to prevent mental or physical harm to employees. Nor is there a difference in the legal obligations to prevent acute

[35] Samuel Harvey and others *Developing a Mentally Healthy Workplace: A Review of the Literature* (A report for the National Mental Health Commission and Mentally Healthy Workplace Alliance, November 2014).
[36] See National Occupational Health and Safety Commission *National Occupational Health and Safety Commission Annual Report 2002-2003* (Canberra, 2003), and Anthony LaMontagne, Kristy Sanderson and Fiona Cocker "Estimating the Economic Benefits of Eliminating Job Strain as a Risk Factor for Depression" (2011) 68 Occup Environ Med A3.
[37] Safe Work Australia, above n 36, at 6.
[38] At 8.
[39] At 10.
[40] At 9.
[41] At 11.
[42] See National Occupational Health and Safety Review Panel *National Review into Model Occupational Health and Safety Laws: First Report to the Workplace Relations Ministers' Council* (October 2008) at chapter 2 for discussion of the impact of changing labour market demographics on rates of work-related mental harm.
[43] MBIE *New Zealand Sectors Report 2014: An Analysis of the New Zealand Economy by Sector* (April 2014) at 39-50.
[44] At 39-45.

or chronic occupational diseases. Since 2004, "harm" has been defined to mean "illness, injury, or both" and expressly includes "physical or mental harm caused by work-related stress."[45]

Applying the hazard management approach required under the HSEA (strengthened under the HSWA), the starting assumption is that each job has a set of hazards associated with the work being done, or working environment, that are "an actual or potential source of harm."[46] There is a set of identifiable hazards associated with building work that expose a builder to injuries, such as falling from a ladder and breaking a leg, or crushing fingers between pieces of wood. Likewise, a social worker working with children who have suffered abuse and neglect may face risks that relate to the psychological impact of that work, be it exposure to traumatic information, emotional exhaustion or the impact of threats of violence. It is, from the perspective of hazard identification, just as foreseeable that a social worker might develop a stress-related illness as it is that a builder might fall from a ladder and break a leg. The presence of the hazards impose the same legal obligation on the employer, yet the employees do not receive the same access to compensation for the resulting harm.

Moving Beyond the 'Accident'

Chronic occupational health problems have had a difficult history in the ACC scheme. "Occupational disease", the term used for non-accidental work-related harm, became a casualty of the type of argument used in the Woodhouse Report[47] to extend cover beyond the workplace. The Woodhouse Report asserted that accidental harms from whatever source were equally deserving.[48] An injury at work was seen as no different from an injury in a traffic collision, an injury on the rugby field, or an injury sustained by tripping over the cat. What made harm compensable in this analysis was not the circumstances of the cause, nor the breach of a legal duty, but rather the harm and resulting incapacity itself. As the report stated, "[i]njury, not cause, is the issue."[49] Essentially, the same harms should receive the same treatment. The problem with this analysis for chronic occupational health problems is that they were not the same harms as the accidental injuries being compared. Occupational diseases were compensated under the prior workers' compensation regime because they were harms "arising out of, or in the course of, employment."[50] It was not the harm, but the cause (employment) which gave rise to compensation. This is perhaps the fundamental distinction between a 'workers' compensation' and an 'accident compensation' scheme. The purpose of workers' compensation is to compensate workers harmed at work. The nature of the harm is less important to determining entitlement than whether the harm was caused by work. The purpose of accident compensation is to compensate accidents and so the entitlement question focuses on whether the harm is an 'accident.' Occupational diseases are not accidents.

Although occupational diseases did not fit the new scheme, they could not be excluded from it, as to do so would deprive workers of an existing entitlement. The original Accident Compensation Act 1972 imported the occupational diseases provisions, as they stood, from the Workers Compensation Act 1956, and described them as an "extension of cover", making their

[45] HSEA, s 2 "harm".
[46] HSEA, s 2 "hazard".
[47] Royal Commission to Inquire Into and Report Upon Workers Compensation (Owen Woodhouse Chair) *Compensation for Personal Injury in New Zealand: Report of the Royal Commission of Inquiry* (1967). Known as 'the Woodhouse Report.'
[48] The Woodhouse Report, above n 49.
[49] At 20.
[50] See discussion in the Woodhouse Report, above n 49, at Part 4.

status as an exception to the 'accident' focus of the legislation clear.[51] The Woodhouse Report anticipated ACC developing into a scheme of universal coverage for all the "hazards of modern living,"[52] including, at a later stage, all diseases.[53] The occupational disease provisions in the original ACC legislation were intended as an interim measure until the broader vision of the scheme could be realised. However, that did not happen. The 1989 attempt to extend ACC cover to all sicknesses and diseases, following an Officials Committee Report[54] and a Law Commission Report (headed by Sir Owen Woodhouse)[55] was scrapped by the incoming National Government in 1990.[56]

The ACC legislation has since been re-enacted and amended many times with attempts to improve the cover of chronic work-related harm,[57] but provisions remain essentially the same, as an uneasy exception; a workers' compensation provision inside an accident compensation statute. The problem with an accident compensation scheme, as opposed to a workers' compensation scheme, is that to ration cover when budgets are tight, the legislation must distinguish between medical conditions. Because it is the harm itself, and not the cause, that gives rise to compensation, lines must be created between different types of harms (physical or mental, accidental or disease) and these lines can be seen in the drafting of the current ACC coverage provisions. For example, what is the difference in principle between catching a disease from handling sheep carcasses and catching a disease from handling chicken carcasses? Yet the eligibility test for cover is different. Why should contracting a disease at work "via an arthropod as an active vector" (for example, a mosquito carrying infected blood),[58] or a dirty syringe, be more compensable than contracting the same disease via infected blood directly? Why should lung cancer caused by asbestos exposure be more compensable than larynx or ovarian cancer caused by asbestos exposure? Why should an ambulance officer who develops PTSD after witnessing a single traumatic event be entitled to cover, when an ambulance officer who develops PTSD after witnessing 500 traumatic events is not? Why is the heart attack of an office worker who lifts a box in the course of employment, but outside of his normal duties, compensable, when a heart attack as a result of years of mental stress or heavy lifting at work is not? The answer is that ACC compensation for work-related harm, although requiring the harm to be caused by work, is still primarily focused on the harm itself and not the work-relatedness of the harm.

To address this exclusion of chronic work-related health problems from ACC cover, the entitlement question needs to be reoriented from the nature of the harm to the causal relationship between the person's work and the harm they have suffered. One approach may be to have a single legislative test for cover that applies to any health conditions that are caused

[51] See Accident Compensation Act 1972, ss 65 and 67.
[52] The Woodhouse Report, above n 49, at 34.
[53] At 144.
[54] New Zealand Officials Committee *Review of the Officials Committee of the Accident Compensation Scheme* (August 1986).
[55] Three reports occurred in the period leading up to the Labour Government's introduction of proposed reforms. See Law Commission *Accident Compensation Scheme: Interim Report on Aspects of Funding* (NZLC R3, 1987), Law Commission *Personal Injury Prevention and Recovery: Report on the Accident Compensation Scheme* (NZLC R4, 1988) and New Zealand Royal Commission on Social Policy *April Report: Report of the Royal Commission on Social Policy* (1988).
[56] See William Birch *Accident Compensation: A Fairer Scheme* (Supplementary paper to the Budget, 1991).
[57] Compare reformulation in the Accident Compensation Act 1982, s 28 "disease due to nature of employment." The Accident Compensation, Rehabilitation and Insurance Act 1992 further amended and reformulated the test for "personal injury caused by gradual process, disease or infection arising out of or in the course of employment" in s 7. Section 30 was most recently amended by the Accident Compensation Amendment Act 2010.
[58] Accident Compensation Act 2001, s 25(2)(c).

by work, whether accidental or disease, acute or chronic, mental or physical. That entitlement test also needs to be drafted widely enough to encompass a broader range of health effects resulting from work. It may be time to accept that ACC is performing a workers' compensation function and to draft the parts of the legislation related to compensating workers towards that function.

Data Collection Implications of Expanded ACC Cover

An extension of ACC cover to any health conditions, mental or physical, that are causally related to work would result in a more comprehensive set of work-related harm statistics being produced by ACC. A more comprehensive dataset would allow for greater research, planning and enforcement activity. Presently, in the absence of ACC data, researchers must either extrapolate from international data or cobble together what they can from Notifiable Occupational Disease System (NODS) notifications, coronial reports, wider public health information and smaller surveys and research projects. The *Report of the Independent Taskforce* highlighted the lack of available occupational health information, stating:[59]

> The Taskforce is left with a profound unease about the quality of data in New Zealand. We are deeply concerned that we do not have a clear, reliable picture of New Zealand's performance.

The Government has responded to this by directing WorkSafe to improve data collection[60] and there is talk of resurrecting and reforming the voluntary NODS. This system has been in New Zealand since 1992, and allows medical practitioners, or the individuals suffering an occupational disease, to notify WorkSafe of their condition.[61] However, even at the height of operation, the NODS only produced a few thousand notifications,[62] and it fell into neglect as a result of policy and internal changes, with its most recent figures at 270 notifications a year (about 20 of which are for stress-related illnesses).[63] The obvious problem with a voluntary notification system is its voluntariness. Unlike applying for ACC cover, informing WorkSafe of an occupational disease will not result in compensation for the worker, or funding for the doctor, so there is little incentive to do it. Extending ACC cover would result not only in better support to workers, but also in better information being collected.

Setting Standards for Healthy Work

The second important way in which New Zealand can start to address chronic work-related harm is through the establishment of clear regulatory standards for healthy work. Regulating for chronic work-related health problems requires two key shifts in thinking. The first shift needed is a move from regulating for 'safety' to regulating for 'health.' The second shift, and perhaps the more difficult one, is an acceptance of the need to regulate areas of the working relationship that have not previously been regulated. Current standards tend to focus on safety over health, and the risk of physical injury over the development of disease. There is a conspicuous absence of regulations, Approved Codes of Practice (ACOPs) and guidelines to address health effects that result from exposure to hazards that are not "plant, substances, and

[59] Independent Taskforce on Workplace Health and Safety, above n 2, at 9.
[60] MBIE *Working Safer: Blueprint*, above n 3, at 20.
[61] Occupational Safety and Health Service of the Department of Labour (OSH) *An Introduction to the Notifiable Occupational Disease System* (May 1994).
[62] OSH *Report on the Notifiable Occupational Disease System to the end of June 1996* (1996).
[63] Department of Labour *Occupational Health Action Plan*, above n 9, at 5.

structures."[64] While there are many improvements to be made to New Zealand's hazardous substances regulation, this paper will focus on the need for standards that relate to health hazards in the working environment, arising from worker interaction with people, poor job design, excessive workload and stress. There are presently reforms in hazardous substances regulation being made and it is the 'non-substance' exposures that are at the greatest risk of neglect.

The Gap Between Act and Regulation

WorkSafe has issued the exposure drafts for the first phase of regulations under the HSWA. The regulations are, in many ways, where the real detail of the *Working Safer* reforms will emerge and where the real battle for chronic work-related health conditions needs to occur. One lesson to be learnt from the HSEA is that the broad and progressive drafting of general duties can be undermined by the absence of regulatory detail in what is required to comply. As mentioned above, since 2004, the HSEA made explicit that occupational health hazards, including mental stress, imposed the same duties on employers as hazards associated with physical injury. The general duties did not distinguish between mind and body, or injury and disease, but the regulations, guidelines and ACOPs certainly did. Anyone looking for concrete direction as to what "all practicable steps" were required to ensure the health of employees would be out of luck. One of the only guidelines available, *Healthy Work: Managing Stress and Fatigue in the Workplace*, was published in 2003 and outlined the available research and provided some tools for responding to stress and fatigue.[65] However, it was focused on encouraging dialogue, rather than setting standards or requiring action. The document explained its approach as follows:[66]

> Creating healthy work is a shared, co-operative venture, where both employees and employers have roles and responsibilities, including the maintenance of a balance between work and non-work activities. It is not something that can be imposed – and it will require mutual understanding, accommodation, respect and the normal processes of give and take for its success.

This approach paints workplace health as 'nice to have' and is a far cry from the "every employer must" approach taken in the asbestos and pipelines regulations.[67] It is an approach that can still be seen. In 2014, WorkSafe adopted the *Preventing and Responding to Workplace Bullying: Best Practice Guidelines*,[68] based on Australian guidelines. While the guidelines document does represent a substantial move forward and provides useful resources for employers in responding to bullying, it still encourages the taking of personal grievances and mediated settlement as its primary enforcement mechanism.[69] It is a gentle 'should' document, not a 'must' regulation, which tries to convince employers that tackling bullying is good for the bottom line, and admits only a very begrudging role for WorkSafe. We would never accept that sort of approach in other areas of health and safety. It would be incomprehensible to tell miners or forestry workers that their only option was to negotiate with the Person Conducting a Business or Undertaking (PCBU) to provide a safe place of work.

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[64] Accident Compensation Act 2001, s 36(3)(d).
[65] OSH *Healthy Work: Managing Stress and Fatigue in the Workplace* (June 2003).
[66] At 2.
[67] See Health and Safety in Employment (Asbestos) Regulations 1996, and Health and Safety in Employment (Pipelines) Regulations 1999.
[68] WorkSafe New Zealand *Preventing and Responding to Workplace Bullying: Best Practice Guidelines* (February 2014).
[69] At 23.

Section 36 of the HSWA requires a PCBU to maintain a "work environment that is without risks to health and safety," provide and maintain "safe systems of work" and "facilities for the welfare at work of workers."[70] There is a large gap between the general duties set out in the legislation and the draft regulations proposed to provide the details of what is required. One example of this gap is in relation to health monitoring. Section 36(3)(g) of the HSWA requires:

> …that the health of workers and the conditions of the workplace are monitored for the purpose of preventing injury or illness of workers arising from the conduct of the business or undertaking.

This drafting is clearly broad enough to include health effects from exposure to psychosocial hazards, unhealthy working environments and unsafe arrangements of work. Yet Part 4 of the draft Health and Safety at Work (General Risk and Workplace Management) Regulations 2015, which provides the detail of this duty, imposes health monitoring duties only where workers are exposed to hazardous substances, and not to other hazards. While these exposure drafts are still being developed and will hopefully change in their final form, it is essential that the new regulations do not continue the old patterns of ignoring chronic occupational health problems.

Moving from Regulating for Safety to Regulating for Health

Regulating for chronic work-related health problems requires a shift in thinking from 'safety' to 'health,' and an awareness that the nature of work, and the workforce, has changed a great deal from that which existed when earlier regulations were drafted. New Zealand's approach to health and safety regulation originates in the Factories Acts of the 19th century and continues to carry the flavour of that time.[71] The American industrialist Henry Ford is often quoted as asking "why is it every time I ask for a pair of hands, they come with a brain attached?" Work in the factories of the 19th and 20th centuries involved hands, more than brains, and, correspondingly, much of the earlier safety regulations were aimed at protecting hands (keeping them from getting caught in machines). As we move into the age of "lights-out" factories without human workers, it is now very possible to buy as many pairs of mechanical hands, unattached to brains, as you might need.[72] Predictions that the majority of workers will soon be replaced by robots[73] may well be overstating things and oversimplifying the nature of the labour market, but there is no doubt that the relationship between technology and work is changing rapidly.

Forbes Magazine releases a top ten list of the skills most sought after by employers. In the 2015 list, all of these sought after skills were mental skills, with collaborating with others, influencing people, and analytical skills dominating the list.[74] Employers are hiring for workers' brains, more than for their hands.[75] Ensuring the health of workers' brains, sadly,

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[70] Sections 36(3)(a)(c) and (e).

[71] Richard Johnstone, Elizabeth Bluff and Alan Clayton *Work Health and Safety Law and Policy* (3rd ed, Thomson Reuters, New South Wales, 2009), see origins discussion in chapter 2.

[72] See "Making the Future" *The Economist* (online ed, 21 April 2012), and Aaron Smith and Janna Anderson *Digital Life in 2025: AI, Robotics, and the Future of Jobs* (Pew Research Centre Report, 6 August 2014) for broader discussion on manufacturing trends.

[73] See public discussion in Ashley Lutz "Three Reasons why Retail Workers Could Soon be Replaced by Robots" *Business Insider Australia* (online ed, 14 March, 2014).

[74] Susan Adams "The 10 Skills Employers Most Want In 2015 Graduates" *Forbes Magazine* (online ed, 12 November 2014).

[75] See Roger Bennett "Employer Demands for Personal Transferable Skills in Graduates: A Content Analysis of 1000 Job Advertisements and an Associated Empirical Study" (2002) 54(4) J Vocat Edu Train 457.

requires very different mechanisms than ensuring the safety of their hands. As set out above, more than three quarters of New Zealand workers now work in services, education or health. These workers deserve regulations designed for the work they do and the health problems that arise from that type of work. The intention of this paper is not to diminish the need for traditional safety regulations, as New Zealand's injury and fatality rates are inexcusably high, but our failures in these areas should not excuse us from continuing to ignore chronic occupational health problems in a changing world of work.

It is common for policy makers, including in the *Working Safer* documents, to fall back on the argument that regulating for healthy work is simply too complex. One common argument advanced against creating standards for healthy work is that the present state of knowledge is too uncertain and we do not really know what a 'healthy' job looks like, or what hazards may result in negative health effects for workers. A second, related argument is that there is simply too much variation in human response to stressors; what may be tolerable for one worker may be overwhelming for another, and so regulating would be ineffective. The first argument, although it sounds reasonable, has the least basis. Quite simply, over the past 30 years, a large and increasing volume of research into worker health and the human effects of work has emerged.[76] We now have decades of research into the subject, including the large longitudinal studies such as Whitehall II,[77] comparative studies, animal studies on blood and brain cortisol levels,[78] neurological studies based on worker fMRI scans, countless case studies, small trials and pilot studies, interviews and surveys. It is simply not true to say that we do not know what a healthy job looks like or which work and organisational practices negatively impact on worker health.

New Zealand can also look to other jurisdictions that are much further ahead in this respect. In November 2014, *Developing a Mentally Healthy Workplace: A Review of the Literature* was produced for the Australian National Mental Health Commission and the Mentally Healthy Workplace Alliance.[79] The United Kingdom Health and Safety Executive (HSE) produced *Management Standards*, which "cover six key areas of work design that, if not properly managed, are associated with poor health and well-being, lower productivity and increased sickness absence."[80] The HSE website states that employers following these standards are adopting an approach that is considered "suitable and sufficient." A similar approach has also been taken by the HSE with musculoskeletal disorders and back pain.[81] Guidance on what amounts to healthy management practice in New Zealand would be a good place to start. There are also a large number of resources available from the Canadian Council of Occupational Health and Safety (CCOHS) on its *Healthy Minds @ Work* platform.[82] There are considerable

[76] For a good review of the literature, see Samuel Harvey and others *Developing a Mentally Healthy Workplace*, above n 37.

[77] The Whitehall II study was set up to investigate the causes of social gradient in morbidity and mortality, based on a cohort of British public servants. The study has produced a large number of scholarly papers including, for example, Stephen Stansfield and others "Work and Psychiatric Disorder in the Whitehall II Study" (1997) 43 J Psychosom Res 1 at 73.

[78] See Robert Sapolsky and Glen Mott "Social Subordinance in Wild Baboons is Associated with Suppressed High Density Lipoprotein-Cholesterol Concentrations: The Possible Role of Chronic Social Stress" reproduced (2013) 121 Endocrinology 5, original produced in 1986. There have been many studies by Sapolsky and others following this significant article.

[79] Above n 78.

[80] HSE "Management Standards" (2007) <www.hse.gov.uk>.

[81] Above n 82.

[82] CCOHS "Healthy Minds @ Work" <www.ccohs.ca>.

resources that New Zealand could draw on, as well as practical assessment tools and measurable standards that might be useful as the basis for developing a New Zealand response.

The second argument against regulation is that the variability of human response to health hazards such as poor management, excessive workload and workplace violence is too great to allow for standards of healthy work to be set. While it is true that workers will react differently to different exposures, this is also the case with physical injuries and hazardous substances. Not all workers will fall from unsafe scaffolding or get their hands caught in unguarded machinery. Not all workers exposed to asbestos will go on to develop cancer. This variability does not prevent us creating a regime in which standards are set for scaffolding, machinery or asbestos, which represent the best available science at the time, and which can be considered safe for most workers. It is also argued that non-work causes of chronic health conditions are too hard to separate from work causes, especially in cases of mental health, heart attack or cancer. Genetics, diet, lifestyle and early life exposure may impact on the development of a disease. This is also true for accidental injury and hazardous substance exposure. Childhood asthma or smoking may make a worker more susceptible to developing occupational respiratory diseases, but that does not prevent the development of standards for the inhalation of hazardous substances containing dusts or fumes. Being older and overweight may make a worker more likely to trip and fall, but that does not prevent us requiring safe lighting levels or safety barriers around hazards.

Accepting the Need to Regulate for Worker Health and Wellbeing

The second shift in thinking required to regulate for chronic occupational health problems is to accept the need to regulate working conditions that lead to poor worker health, including potentially management practices, job design, working hours, social interaction in the workplace, worker autonomy and participation, performance and remuneration systems. This shift is likely to be much more difficult than determining 'how' to regulate for worker health. There is considerable resistance to regulating for healthy work, as such regulation ventures into fiercely guarded managerial prerogative and is perceived to create a level of state involvement in business decision-making that is unpopular in the current political climate. Addressing the chronic health effects of work, especially effects on mental health, also requires a recognition of workers as human beings, complete with all the social, psychological and emotional needs that humans have.

New Zealand's approach to health and safety regulation reflects the wider political changes that took place in the 1980s, when the HSEA was being drafted and redrafted.[83] When it was finally enacted in 1992, the HSEA was hailed as the "completion of 'the triad'" by employers, following the introduction of the Employment Contracts Act 1990 and the Accident Rehabilitation and Compensation Insurance Act 1991.[84] It was intended to move control of health and safety from a paternalistic government to the hands of employers and managers in individual enterprises. The *Working Safer* reforms continue to place primary control of health and safety in the hands of employers, declaring that an overly prescriptive approach would stifle the innovation and creativity needed to grow new businesses.[85] However, as set out above, regulating for worker health does not need to look like, nor should it not look like, 20th century

[83] For discussion of this history, see Allen and Clarke *Occupational Health and Safety in New Zealand: NOHSAC: Technical Report 7* (NOHSAC, 2006).
[84] See discussion in New Zealand Council of Trade Unions *The Dupes of Hazard: A Critical Review of the Health and Safety Act 1992 in Practice* (CTU, Wellington, 1994) at iii.
[85] MBIE *Working Safer: Blueprint*, above n 3.

regulations for factories and mines. Regulations do not need to prescribe what each job must look like, what tools and equipment must be used, or when and where a worker must perform their tasks. Regulations for healthy work should take a very different form and should be coupled with a very different enforcement mechanism to traditional safety regulations.

New regulations could, for example, set out a list of the requirements for a healthy job (including that the job must have a fair and manageable workload, have appropriate training and supervision, allow for variation in tasks and an appropriate level of decision-making, and so on). An individual's job can be measured against this list of characteristics and the PCBU can, based on this assessment, make changes to the job. If a job falls short, a worker can use this assessment in combination with the proposed new HSWA tools to request that changes to the job be made. Where the changes requested by the worker are "reasonably practicable", the PCBU would be obliged to carry them out in order to meet their primary duty under s 36. Having a regulatory standard for a healthy job would require the health of workers to be considered in the process of job design or redesign, including organisational restructuring. Ideally, it would make the consideration of worker health a clearer legal requirement when making decisions about how work is to be performed, and assist in forcing the duties contained in the HSWA onto the boardroom table.

Reforms to HSWA Enforcement Machinery

The third reform proposed in this paper is the development of a new enforcement tool under the HSWA. Aside from *Nalder & Biddle*[86] in 2004, there has been little prosecution action in relation to the types of chronic health problems that are the focus of this paper. It remains to be seen whether the newly empowered regulator will take a stronger role in relation to occupational health, but the exclusion of these conditions from the national targets and the focus on 'priority industries' makes this seem unlikely. The previous position of the Department of Labour in relation to mental health problems, stress-related illnesses and health problems resulting from the arrangement of work was to encourage mediation provided by the Employment Relations Mediation Service and resolution through negotiated settlement. As discussed above, in the absence of ACC cover, the personal grievances regime has also stepped in to fill the void. This de facto enforcement role for the personal grievances regime looks set to continue under the HSWA, if not expand further.

Enforcement by Prosecution or Personal Grievance

The WorkSafe New Zealand Act 2013 and the HSWA create a regime of increased regulator power and tougher penalties. The goal of reducing fatalities and injuries by 25 per cent in 2020, along with the appointment and training of additional inspectors, seems to have driven a renewed emphasis on prosecution.[87] However, an increased willingness to prosecute where serious accidents have occurred does not necessarily translate into an increased willingness to require employers to make structural changes to a person's job in the name of mental health. It is unclear what action the inspectorate will feel empowered to take when health and safety problems relate to staffing levels and skill mix, rostering and hours, supervision and management, or the alteration of remuneration and performance systems. Historically, there has been a reluctance to 'tell businesses how to run their organisations.' This makes sense, as

[86] *Department of Labour v Nalder & Biddle (Nelson) Ltd*, above n 35.
[87] MBIE *Working Safer: Blueprint*, above n 3.

intervening may be politically unpopular, complex and potentially embarrassing for the government. Take, for example, the situation in public hospital nursing. The inspectors are unlikely to require hospitals to improve staff-to-patient ratios and reduce health practitioner workloads in the name of safety as that would, almost certainly, require additional public health funding, alterations to the budget and to health policy.

The HSWA allows for private prosecutions under s 144. Private prosecutions provide unions an option to pursue test cases in industries with high mental hazard profiles, but are unlikely to offer a solution to New Zealand's occupational chronic harm problems, especially given the difficulties in proving causation 'beyond a reasonable doubt' and the associated costs. In all likelihood the personal grievances regime, civil claims and mediated settlement will continue to operate as the primary mechanisms for addressing chronic health problems caused by work and excluded from ACC. The role for private enforcement through civil claims may expand further, with the potential for an 'adverse action grievance' and a rise in breach of statutory duty claims on the back of a widening number of people owed a duty under the HSWA.

Subpart 5 of Part 3 of the HSWA creates offences in relation to adverse conduct, such as dismissing an employee from employment, depriving a worker of benefits or refusing to renew an engagement in retaliation for a worker's involvement in health and safety action.[88] It also allows for civil proceedings under s 95 to be brought. However, s 95 excludes employees and their representatives from using this action. From the drafting of s 97, it would seem the HSWA anticipates that adverse conduct would be dealt with by an employee taking a personal grievance, but that this is confined only to a personal grievance and not to other types of proceedings an employee may have available. The courts are yet to interpret s 97, but it does appear that employees have a lesser ability than other 'non-employee' workers to take civil proceedings to challenge adverse conduct by their employer. This provision departs from the approach taken in the Australian Model Laws, which allowed for all workers, employees or otherwise, to bring proceedings under the equivalent section.[89] Assuming the employee can prove a grievance, they would then be limited to the personal grievance remedies, as opposed to the wider range of remedies under s 95, and also be limited by the personal grievance timeframes, usually 90 days as opposed to one year under s 95. The drafting of these provisions seems to push yet another key health and safety protection into the personal grievance regime and mediated settlement.

The second potential change in enforcement under the HSWA may be an expansion in claims for breach of statutory duty. The shifting of duties from employer to PCBU has expanded the number of people owed duties under health and safety legislation and regulations. In a recent article, Foster and Apps trace the use of breach of statutory duty claims under the Model Work Health and Safety Law in Australia,[90] offering insights into the way the claim may be used under the New Zealand HSWA. Recent Australian decisions have held that safety regulations may impose a higher standard of care than the general duty of care imposed on employers, and that a finding of breach of statutory duty can be made without a finding of negligence.[91] This was also decided in a recent United Kingdom case. In *MacDonald v National Grid Electricity*

[88] Section 88.
[89] Model Work Health and Safety Act, s 112.
[90] Neil Foster and Ann Apps "The neglected tort – Breach of statutory duty and workplace injuries under the Model Work Health and Safety Law" (2015) 28(1) Austl J Lab L 28 57.
[91] *Veljanovska v Verduci* [2014] VSCA 15, 42 VR 222 at [28] and *Pasqualotto v Pasqualotto* [2013] VSCA 21 at [216].

Transmission plc,[92] McDonald sought compensation for lung disease caused by asbestos exposure. His claim in negligence against his employers failed as the circumstances of his exposure did not create a "foreseeable risk at the time," but his claim that the occupier of the plant breached its statutory duty under the Asbestos Industry Regulations 1931 was successful in the Court of Appeal. As Foster and Apps point out, the breach of statutory duty claim may expand the situations in which liability may be established.[93] For those cases excluded from ACC cover, or those workers excluded from the personal grievances regime, the expanded duties under the HSWA may offer a new option for seeking compensation. If new regulations for healthy work are established, the options for workers affected by these health conditions are also potentially increased.

Despite the creativity of New Zealand employment lawyers in moulding personal grievances, contract and tort actions to fill gaps in the law, these claims remain a fundamentally unsuitable mechanism for obtaining treatment, rehabilitation or compensation for work-related harm, or for the enforcement of New Zealand's health and safety standards. These actions simply were not designed to do the job that ACC and occupational health and safety legislation should be doing. An effective response to chronic occupational health problems requires reforms to ACC coverage provisions and a better set of regulations and enforcement tools.

Is a 'Right to Request' Needed in the Health and Safety at Work Act 2015?

One possible way of addressing the enforcement difficulties above, while still working within the overall framework of the HSWA, could be the introduction of a 'right to request,' similar to the flexible work right to request under s 69AAB of the Employment Relations Act 2000. With such a tool, a worker, health and safety representative or union is granted an explicit statutory right to request certain actions on the part of the PCBU, which could only be refused if the action requested was not "reasonably practicable." For example, the worker(s) or their representative(s) might request:

- Changes to work (including working patterns, job design or workload allocation) on the grounds of worker health or safety;
- Changes to a workplace policy, practice or decision on the grounds of worker health or safety;
- That particular actions be taken to ensure a worker can perform their job without risk to safety and health;
- An independent review of a worker's job or workload to assess whether the job is capable of being safely performed by the worker; or
- That tests or an independent assessment of worker health be carried out.

A right to request would be consistent with the primary duty of care imposed on a PCBU under s 36 of the HSWA. A PCBU has a legal obligation "to ensure, so far as is reasonably practicable, the health and safety of workers,"[94] and a statutory right to request simply creates a mechanism for workers to ensure those reasonably practicable actions are taken.

The power behind a right to request tool is that a PCBU refusing such a request exposes itself to a claim that it failed to discharge its general duty of care under s 36. A PCBU decision to

[92] [2014] UKSC 53, [2015] 1 AC 1128.
[93] Neil Foster and Ann Apps, above n 92, at 59.
[94] Section 36.

refuse could be subject to review, either by the regulator or the court in a public or private prosecution. This process would allow the inspectorate to take a greater enforcement role in relation to occupational health without the problems associated with the inspection of complex psychosocial hazards. Essentially, an inspector could review a written request made by the worker(s) and the written response by the PCBU to assess its 'reasonableness.' This is a far easier (cheaper and quicker) task than attempting to evaluate job design, management structures and working patterns to assess whether they amount to a breach. The task of assessing the reasonableness of a decision might also allow for judicial determination in situations where there has not been a notifiable event. For example, a decision that a particular employer's refusal to make changes in working practices was not a reasonable one might serve as a precedent for that industry more broadly.

A statutory right to request, as opposed to merely an obligation to be consulted with, could greatly strengthen workers' abilities to address occupational health issues, either individually in relation to a specific job or collectively in relation to organisational policies that have a negative effect on worker health. Unlike a private prosecution or a breach of statutory duty claim, workers do not have to sue the PCBU, prove fault or wait until someone is harmed, they are enabled to request specific changes to ensure their health and safety and are provided with an assurance under legislation that the PCBU must make those changes unless they are unreasonable or some other alternative can be negotiated between the workers and the PCBU. A right to request also allows for an action which is not barred by ACC legislation, as it is not based on seeking compensation for harm, but rather changes to working practices. A right to request tool is directed at changing behaviour and prioritizing health and safety and could potentially allow for more complex occupational health issues associated with shift work patterns, poor job design or staffing levels to be addressed.

Conclusion

This paper argues that addressing the "tragic paradox" of New Zealand's response to chronic work-related harm requires reform in three key areas. First, the coverage provisions of the ACC scheme need to be reoriented from the nature of the health problem to its 'work-relatedness' and extended to cover a wider range of health conditions. An extension of cover would provide financial support and rehabilitation to a greater number of workers and allow for better information collection on occupational health. Second, this paper argues that a change in willingness and approach to regulating for healthy work is needed. Setting standards for the health of workers' minds is different to setting standards for the safety of workers' hands. The changing nature of work and the workforce in New Zealand requires us to challenge our assumptions and develop a new form of regulation for worker health. Thirdly, this paper argues that to accompany a new set of standards, New Zealand needs to develop a new set of enforcement tools. One such tool may be a statutory 'right to request' that enables workers to deal with hazardous work before it results in health problems.